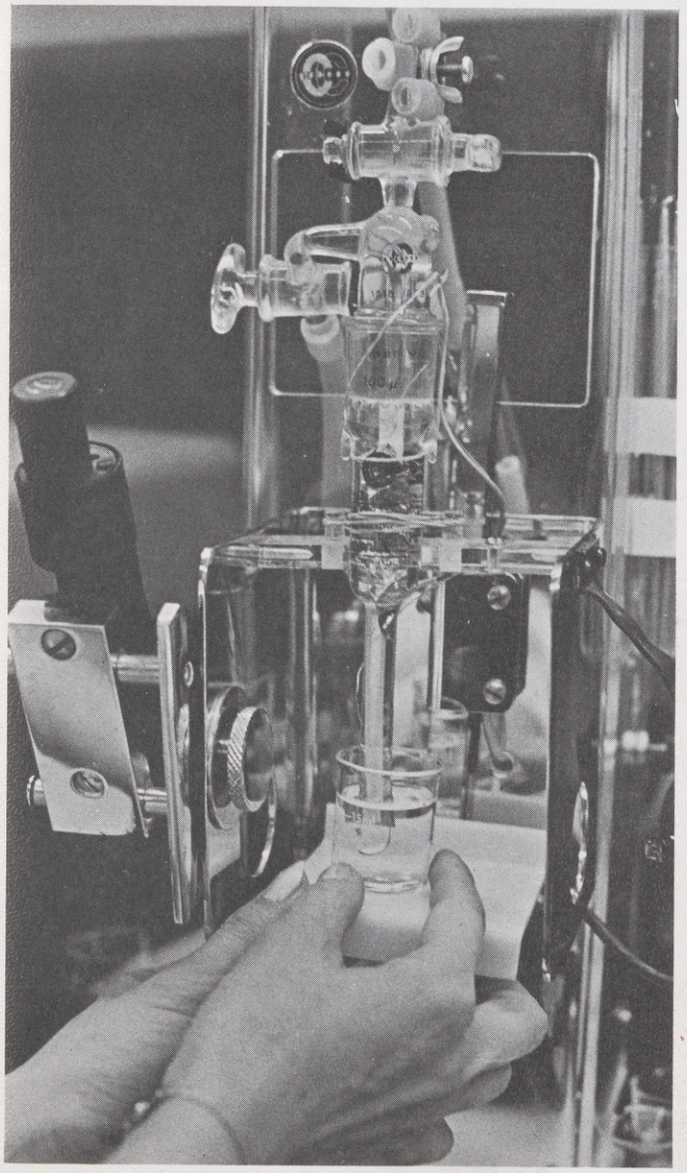
u.c. medical center news
published by the u.c. hospitals auxiliary

Volume I Number 7 San Francisco, California May-June, 1968

A TALE OF TWO CLINICS

Where there's hope and help



Discoveries rooted out in laboratory experiments such as this one in the cancer research facility at UC Medical Center can bring relief from pain or a retarded rate of disease. Chemotherapy's the key to many contemporary treatment programs.

In 1977, wizard computers estimate there will be 248,000 outpatient visits to the clinics at the University of California Medical Center in San Francisco.

Construction of a new, nine-level clinics building and expansion of personalized medical services will make this number possible.

Right now, there are more than 50 outpatient clinics of the schools of medicine and dentistry housed in the 35-year-old Clinics Building on Parnassus Avenue.

To these clinics come patients from all over California, and from out of the state, too. Each patient has his special, sometimes agonizing problem. It might be crippling arthritis, a puzzling hormonal deficiency, a rare blood disease, a mal-functioning lung. It may be heart disease. Or it may be cancer.

Statistics in the Cancer Research Institute Clinic echo the predictions for the burgeoning number of outpatient visits nine years from now. In 1958, according to Dr. Edwin Jacobs, there were 350 outpatient visits a year to that clinic. In 1968, there will be 5000 outpatient visits.

As a clinic's work and reputation are recognized, its patient load is bound to increase. So are its staff and its equipment and the demands on both.

Two clinics where things are happening in the professional and "just plain people" departments are cancer research and cardiac clinics at UC Medical Center.

In both, the focus is clearly on a team philosophy. Where patients return again and again for treatments, as they do in both cancer and cardiac clinics, barriers between professional staffers and patients are washed away and genuine friendships often spring up.

The working team in the cancer research clinic embraces doctors, nurses, social workers and volunteers. The same is true in the cardiac clinic, where a challenging new volunteer-staffed program is earning Gold Stars and applause from the professionals.

What goes on in the world of clinics? A world where patients with often critical diseases live a reasonably normal work-a-day life between treatment visits. Is it depressing, frenetic and does anybody care? An inside look and a tale of two clinics are featured in this issue in the inside pages.

CANCER RESEARCH

A clinical view

"We take patients with incurable cancer if we can do something about the length and quality of their survival.

"Our goal is to help them live longer and to eliminate as many symptoms as possible."

Soft-spoken, dark-haired Dr. Edwin Jacobs, head of the cancer research unit in Moffitt Hospital, has some no-nonsense notions about his patients.

"I think the emphasis should be AWAY from cancer patients being unlike other patients. It's time the cancer patient was NOT discriminated against.

"Other things can be serious, too. A stroke can be more critical than cancer. Angina pectoris is a critical illness. So is emphysema."

Dr. Jacobs feels he can speak from experience about his association with cancer patients.

"I've worked with cancer patients since 1955. It takes a long time to learn not to discriminate. Medical students and doctors who see only a few cancer patients find it a difficult disease to look at. Doctors have their fears, you know."

At the UC Medical Center cancer research institute clinic in Moffitt Hospital "we try to be as honest as we can with patients," Dr. Jacobs says.

"If a patient wants to know — we tell him. We tell him what he can do about his condition, where he can get help. If he wants more specific information, we tell him that his disease in a few years may lead to his death."

What if a patient demands to know 'how long do I have, doctor?' Dr. Jacobs refuses to play this kind of guessing game. "I really would not like to be wrong," he says wryly.

"I remember one girl who came here months ago with the prediction that she had two weeks to live. She's alive today because of chemotherapy."

Chemotherapy employs the use of drugs for treatment of advanced cancer. The challenge: to find a drug which will destroy cancer cells without destroying other cells.

"What we have today," laments Dr. Jacobs, "are drugs that are only partly successful. They may damage tumor cells, but they may also harm normal cells.

"The problem is the difference between the bacterial cell and the human cancer cell. The bacterial cell is a foreign invader. The cancer cell is the patient's own cell."

Dr. Jacobs feels now that the medical profession is "in the exploratory phase" with chemotherapy.

"Before World War II, nobody would have considered treating cancer with drugs any more than they would have treated pneumonia with sulfa."

The idea of treating cancer with drugs was born, strangely enough, from studies of the toxic effect of mustard gas on lymph glands and bone marrow. These explorations were born out of experience in World War I.

"From 1942 to 1946, studies were made which resulted in treatment of cancer with mustard compounds, then with other types of treatments," the clinic chief continued.

"Anti-metabolics, for instance, are chemicals which mimic the chemistry of the human body and show chemical reactions of cells and how to block their normal function."

The other big group of miscellaneous treatment drugs includes plant extracts and anti-biotics. There are about 50 of these but far fewer are in common use, according to Dr. Jacobs.

Dr. Edwin Jacobs
'Stop discriminating'

There are advantages from chemotherapy which extend to patients other than those suffering from incurable cancer. Chemotherapy helps medicine "learn more about the treatment of cases we used to reject as hopeless," Dr. Jacobs contends.

Another fringe benefit is an extension of the knowledge of cellular biochemistry and of the function of the cancer cell. This secondary knowledge may lead to a fundamental knowledge of cell function as well as the cause of the change from normal cell growth to the uncontrolled spread of cancer cells.

"There have been tremendous advances in the last few years — nothing sudden or dramatic. But we are learning to care for patients with a chronic disease, and I mean heart disease as well as cancer. We no longer give people morphine and just send them home to die."

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'People may come here for years'

A leggy young brunette with short-cropped hair . . . an elderly gentleman resting in a wheelchair . . . an attractive ash-blonde in her 30's who smiles "just fine" when someone asks how she feels.

It's clinic day in the cancer research unit on the 12th floor of Moffitt Hospital.

On Tuesdays and Thursdays, an average of 50 outpatients are scheduled for appointments each day.

Clinic days are busy days. People line up in the halls for weigh-ins, for blood counts, for doctors' appointments. They may come week after week, month after month, even year after year.

Jeanne Yalon, a head nurse in the out-patient unit, knows nearly everybody by first name "and all by last names." She feels this is important. "When they come often, recognition means something."

"We don't mask the word 'cancer' here. Patients get to know each other and to talk freely about their problems. It's a good thing," Mrs. Yalon says candidly. "They find out some others are worse off than they are."

Patients find their way to the clinic through referrals from other departments in the hospitals, from their own doctors, from other doctors in other hospitals.

"We have someone who comes regularly from Portland for treatment," Mrs. Yalon revealed. "Another patient flys in from Tahoe regularly, and we have a prisoner who comes every week from San Quentin."

If somebody "just walks in," he is asked to go to a medical clinic for an evaluation. "If people call, we advise them first of all to see their own doctor."

Some patients work full time and come in regularly for a treatment, then go right back to the office. This routine may continue for years.

Head nurse in the in-patient section of the cancer research section, Irene Stock, knows most patients by their first names and feels it's important to them.

According to Irene Stock, head nurse for the in-patient unit, the theory is "get patients back into a home situation as soon as possible."

"But patients always get to know us, and it gets to be a 'one big family' kind of thing."

The close coordination of in- and out-patient units in the cancer clinic is unique "in any hospital I ever heard of," Miss Stock believes.

In-patients usually number about 22, and 18 are treated in the cancer research facility and four with radiation therapy. The youngest patient Miss Stock remembers was age 14.

Does she ever get depressed with her work in what many might regard as a 'hopeless' world? "Never," she says emphatically. "I couldn't tell you why, but working here is certainly NOT depressing. We try to keep patients independent and doing everything they can do within their physical capabilities."

Are there special requirements in hiring staff for the clinic? "Not especially," Miss Stock contends. "Sometimes, if we get terribly busy and have seen many patients with many problems, we may get to the point where we can't take it. But we sit down then and talk person-to-person.

"And there's a weekly meeting with a representative from the psychiatric department. We talk to Chaplain Elmer Laursen. Doctors and social workers are guest speakers, too."

Miss Stock believes in a "fair and realistic appraisal" for patients of their illness and its potential. The basic philosophy in the clinic is "patients should know their diagnoses."

"We rely on the doctor to tell the patient, although we have situations where patients are not told. Often, physicians prefer to discuss the case with the family first.

"Each patient reacts in a different way. One may talk frankly and openly. Another may approach the subject of cancer in a roundabout way.

"People sometimes need time to work out their own feelings before they ask questions or even before they can talk about their illness."

No matter how a patient may respond to the shock of the news 'you have cancer,' Miss Stock is sure of one thing:

"We always encourage planning for the future."

CARDIAC CLINIC

Volunteers get a go-ahead

A woman walks into the cardiac clinic and says fiercely: "If I die of a heart attack, it will be my husband's fault!"

An anxious-looking young man with a severe heart problem sits down and folds his arms and says flatly: "I will NOT answer any questions about how I feel. It's none of your business."

In some cases, these emotional flare-ups signal the need for prolonged psychotherapy. In most instances, it reveals a lonely, frightened human being who needs somebody to talk to.

In the cardiac clinic at UC Medical Center, that "somebody" may be a trained volunteer.

Now under full sail after its pilot launching is a project triggered by physicians, nurses and social workers in the clinic and now staffed by dedicated volunteers.

"What it boils down to is a realistic use of professional time — the doctor, the nurse, the social worker and the volunteer all doing their special things."

This is the cheerful appraisal of Helen Brenenstuhl, one of 17 social workers who are assigned to cover 60 clinics at UC Medical Center. She is assigned part-time to the cardiac clinic and part to cardiovascular research.

"With heavy caseloads, we just can't give the help we should to individual patients," Miss Brenenstuhl explains. "You see people who are obviously working too hard, exerting themselves, living on starvation budgets, even in pain. There just isn't time to explore every single problem."

Faced with increasing patient visits in the cardiac clinic, the social worker — with approval from Drs. Maurice Sokolow and John Sampson — decided to launch an experiment.

"I asked Sue Carlisle, the coordinator of volunteers for the hospitals, if she could find people to interview all our new patients and screen them for special problems."

The first interview census conducted by volunteers involved 34 patients and gave the first realistic picture of the kind of people who come to the clinic.

For the first time, a personal interview is being conducted and a questionnaire filled out with the help of volunteers such as Barbara Doubleday in cardiac clinic.

"The volunteers were superb," Miss Brenenstuhl applauds. "Their reports were amazingly perceptive. Even people who felt they 'weren't supposed' to talk about intimate problems — such as frigidity — DID talk to the volunteer."

Staff and volunteers then proceeded to draw up an original four-page questionnaire which is now being used regularly in the cardiac clinics with new patients.

So far, eight volunteers have taken part in the project. Still active are: Darlene Klaif, a former psychiatric nurse; Marjorie Stauffer, a retired social worker; Barbara Doubleday, a clergyman's wife; Freda Farber, wife of a physician.

"Persuading people to answer questions isn't always easy. These women are wizards. Like the young man who said he 'refused to answer.' In half an hour, he was smiling at the volunteer and saying 'it was great talking to you,'" Miss Brenenstuhl says.

So far, volunteers have shown remarkable perception in their interview findings. They have been able to refer every patient with a significant psychological problem to a social worker for an evaluation.

But there are alternatives. The woman who said her husband would be to blame if she "died of a heart attack," for instance. After exploring the problem, the social worker decided she didn't need any professional help.

"The main thing anyone could offer her was a sympathetic ear for her fears and complaints," Miss Brenenstuhl points out. "In this case, the volunteer who saw the woman regularly gained her confidence and was able to ease her into seeking help from a family counseling agency."

Patients, staffers and volunteers met recently in cardiac clinic to hear Dr. Rambie Briggs discuss "What is Heart Disease?"

VOLUNTEERS GET GO AHEAD

(continued from previous page)

The volunteer can sit for an hour and listen to a recital of problems, aggravations and downright terror. She can also determine through the questionnaire these vital facts: Does the patient live alone? Does she live in a cold, damp or noisy apartment? Does she climb stairs or hills? What transportation does she take to the clinic?

Volunteers are in the clinic from 1 to 5 p.m. one afternoon a week. "We have five volunteers two days a week and four on one other day. We have space for 14," Miss Brenenstuhl says.

This pilot program only scratches the surface, Miss Brenenstuhl feels. Volunteers are needed to do these things, too:

- Telephone every patient who breaks an appointment. Doctors are intensely interested in this study. The project is drawn up and approved. Only volunteer muscle is needed to make it go.
- Make a statistical study of why people cancel appointments. In six months, the clinic would know if patients didn't feel well — or felt too well to need to come — or had no money for transportation or had another doctor.
- Help organize a discussion group for patients who come early for doctors' appointments and have time to spare. One such recent meeting involved a young resident, who spoke on "What is Heart Disease?" It was a roaring success, according to Miss Brenenstuhl.

"Why not invite a dietitian in, and speakers from Vocational Rehabilitation and the Employment Service to talk about problems of cardiac patients?" the social worker suggests.

"If I had enough volunteers, we could arrange weekly or monthly counseling interviews," she adds. "Patients who are isolated and have no families need someone to talk to. One of the major factors in illness and deterioration is loneliness.

"When patients have someone to talk to, it lessens anxiety and motivates them in the right direction — such as keeping their appointments at the clinic and taking better care of themselves. There's a feeling that 'somebody cares what happens to me.'"

"All these things are what we really want to do," Miss Brenenstuhl says hopefully.

"I'll be disappointed with just a finger-in-the-dike treatment. There's so much to be done."

Helen Brenenstuhl
'More to be done'

THANK YOU, DONORS

Gifts can boost medical progress

Among donors in the months of March and April, whose gifts will make possible in the future improved programs in training, patient care and research at UC Medical Center, were:

Gifts of over $50: Allen Foundation; American Cancer Society; American Heart Association; American Medical Association, education and research foundation; Dr. William W. Anderson; Bay Area Research Committee; Bechtel Corp. Employes.

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Among donors of gifts amounting to $5 to $50 are: Zoe N. Aaronson; American College of Dentists, Northern Calif. Section; Mr. and Mrs. John Avanzino; Mrs. Eleanor Barbieri; Stanley C. Bateman; Mr. and Mrs. Al Bates; Mr. and Mrs. Ernest Bonney; Mr. and Mrs. Alfred M. Bordin; Mr. and Mrs. William W. Bruce; Anne S. Brunton; Mr. and Mrs. Paul Burbage.

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Frank E. Mikesell; Dr. J. Fraser Muirhead; Dr. and Mrs. Thomas Nelson; night staff of Chinese Hospital; OB-GYN Group, UC Medical Center; Carol Packard; Mr. and Mrs. Joe Pastorini.

Attorney Richard Ham, new president of UC Hospitals Auxiliary, receives the gavel and congratulations from outgoing auxiliary chief, Mrs. A. Downey Orrick.

Richard Ham elected head of Auxiliary

It is "Mr. President"—not "Madame President" — for the next term in the UC Hospitals Auxiliary.

The man behind the office is Richard Ham, attorney and auxiliary board member for several years. He succeeds Mrs. A. Downey Orrick as auxiliary chief.

Election of Ham to the top office was announced at the recent annual meeting of the UC Hospitals Auxiliary in the Medical Science Auditorium at UC Medical Center.

During 1967-68, the auxiliary donated $6000 to patient amenities and the finance committee is now considering a further contribution of more than $2800, according to Mrs. Orrick in her annual report to auxiliary members.

Fund-raising activities of the auxiliary last year included a "Holiday Workshop" and the opening night of the Marlene Dietrich show in San Francisco.

A Chaplain who's part of the team

Crisp yellow curtains billowed in the breeze from the windows, and the hi-fi hummed a soft tune. In the next room, a sandy-haired man in a clerical collar talked on the telephone:

"He started with marijuana and then switched to LSD and then got hooked on methedrine. He really wants to kick the whole thing. Do you think you could see him on Monday? Fine. Fine. Thanks so much."

Chaplain Elmer Laursen, S.T.M., turned around in his chair and sighed.

"Thank goodness they can see him at the psychiatric clinic. I just don't feel there's much I can do about the drug problem."

Lanky, bespectacled Chaplain Laursen has strong convictions about his role as minister-on-the-scene at UC Hospitals since 1960.

"The traditional picture of a chaplain is outdated, out the window. A patient could be insulted if a minister walked into his room without an invitation and offered to read the Bible or to recite a prayer."

Then what does a chaplain do? "My basic role as a member of the healing team is to help people get well and get out of the hospital. A chaplain shares the concerns of the nurses and doctors and TRIES to share their problems."

It was UC Hospitals administrator, Harold Hixson, and dozens of nurses who felt there was a need for regular chaplaincy services in the hospitals. Elmer Laursen's expenses are paid by Lutheran Social Services of Northern California, and he supervises three full-time interns from Lutheran and Baptist seminaries. He is delighted with the warmth of his welcome at UC Hospitals.

"Now that ambulatory medicine is so firmly entrenched, the demand is for more and more counseling," Chaplain Laursen believes.

Nurses are often key referral sources for Chaplain Elmer Laursen's services. At UC Hospitals since 1960, he also supervises three intern ministers there.

"We work on referrals from nurses or physicians or from patients themselves. There are always people who are anxious and depressed, concerned about a diagnosis, about surgery or about slow recovery."

Chaplain Laursen doesn't believe in trying to see "every patient in the hospital — with 40 admissions a day, that would hardly be possible."

Patients themselves often ask to see the chaplain. Why? "If they are in a hospital, they are afraid, whether they belong to a church or not. Everybody has anxious moments.

"When you face surgery — or death — you face it alone. Here at UC, which is so big, people are afraid of being a number instead of a patient. They want somebody to talk to besides nurse, doctor or family. I've never been rejected by a patient here. Nobody's ever thrown me out.

"A religious person asks for a minister because that's what he is used to. I'll buy that. People with no religious faith often just plain want somebody to talk to."

"Maybe people feel there's a special quality about ministers," the chaplain reflected, "a comforting quality, perhaps. Even scientists reach out for it in time of illness. I usually kid them and say 'you just want to cover all the bases.'"

The question of suicide occurs frequently in the chaplain's conversations with patients, especially those with critical ailments and negative prognoses.

"The last thing to do in these cases is to tell someone NOT to do something. I just try to help people tap their own resources when they are in this kind of trouble."

What's the greatest problem people face as patients? "Loneliness. I see it scattered all over in men and women. I'm glad to see the volunteer movement increasing. Volunteers are seldom lonely. They are so amply repaid by the response to their services. This is a big antidote to loneliness."

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Dr. Marjorie S. Dunlap To Head Nursing School

Dr. Marjorie Snyder Dunlap, dean of the University of Hawaii's School of Nursing since 1966, will succeed Dr. Helen E. Nahm as dean of the School of Nursing at UC Medical Center next February.

Dr. Nahm is retiring after 10 years as head of nursing on the San Francisco campus.

Dr. Dunlap, 51, is a graduate of University of Missouri and received her diploma from Washington University School of Nursing in 1942. She holds a master's degree from University of Colorado and a doctorate in education from University of Southern California.

A former consultant for World Health Organization in Chile, Dr. Dunlap taught at schools of nursing in Kansas City and Denver and was director of a nursing service administration project at University of Colorado before coming to the UCLA School of Nursing in 1956.

Dr. Marjorie Dunlap
School of Nursing Dean

Stanley Powell: a good friend to UC Hospitals

"He was a man with a great sense of humor, beloved by all and dedicated to the well-being of others. He showed this prominently in his devotion to the University of California Hospitals Auxiliary Board."

Immediate past president of the UC Hospitals Auxiliary, Mrs. A. Downey Orrick, paid this tribute to the late Stanley Powell at the auxiliary's annual meeting in May.

Mr. Powell, retired business executive and long-time leader in San Francisco's civic and cultural circles, died recently after a brief illness at Children's Hospital at age 76.

For many years, Mr. Powell was chairman of the nominating committee of the Auxiliary.

As a tribute to Mr. Powell's memory, Mrs. Orrick has suggested that a room at UC Hospitals be named in his honor.